Sustaining meaning in life, maintaining emotional well-being, and balancing attachments to the living and the deceased are features associated with the psychological (and often private) impact of loss. In the Two-Track Model of Bereavement, the loss process is conceptualized along two distinct but interactive axes that attend to these overt and covert aspects of the response to loss. Whereas Track I is concerned with biopsychosocial functioning in the wake of loss, it is Track II that focuses on the bereaved’s ongoing emotional attachment and relationship to the deceased. The contributions of the model to theory and research can serve to clarify our thinking about bereavement as a process resonating throughout one’s life. Initially, research and clinical findings from bereaved parents are presented to illustrate the Two-Track Model and its contribution to the deepening of our understanding of loss throughout the life cycle. The contributions of the model to clinical practice are then considered for their ability to clarify our thinking and interventions. Two clinical cases illustrate situations where a predominant focus is on one or the other of these tracks. Ultimately, the Two-Track Model of Bereavement’s use extends to the organization and clarification of theory, research, and clinical work.

The lifelong effects of some losses, and the seemingly transient effects of others, have confused writers, clergy, physicians, and scientists in their attempts to conceptualize loss. The mixture of overt and covert aspects of the loss experience, as well as the confusion of symptomatic response, coping behaviors, and long-term

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influences of loss further complicate the picture. It is the goal of this article to sketch the basic framework of the Two-Track Model of Bereavement as it relates to theory, research, and clinical work. As will be seen over the course of the article, the structure of the model provides a degree of clarity for this field whose centrality to the experience of humankind cannot be overestimated.

When confronted with the loss of a loved one, the emotions experienced are profound and familiar (Siggins, 1966). There are alternative theories as to what these emotions express. Perhaps at a minimum, it may be said that they all reflect the response to the inability of the bereaved to protect either oneself or one’s close relations from the realities of death, and that it is not even possible to maintain the pre-loss bond to those we love following death. The combination of our inability to control fate, together with the permanent severance of contact with a loved one, simultaneously attack two foundations of human strivings: the wish to be with one’s significant relations, and the wish to be able to influence one’s surrounds (Bibring, 1953). Deprived of those we love, and deprived of the ability to affect the world we live in, it is no wonder that we suffer the loss of a loved one with such devastating impact (Brown & Harris, 1978; Janoff-Bulman, 1992; Parkes, 1975).

For most bereaved, time will heal the sharp pangs of loss. The acute reactions will subside and there will be a return to a physiological, cognitive, interpersonal, and intrapersonal homeostasis. People are adaptive organisms, with the ability to form and sever relationships (Attig, 1996; Neimeyer, 1998). Yet despite this, the loss will generally cause permanent effects in personality and/or the life course of the bereaved individual. These changes will vary from person to person as will the awareness of these changes by the individual and his or her surroundings (Doka, 1989; Worden, 1992). Sometimes, the direction of change will result in an appropriate reorganization with adaptive features, and at other times the reverse will be true. Perhaps the most common outcome to loss is a combination of subsequent favorable and problematic features (Malkinson, Rubin, & Witztum, in press).

With a broader view of bereavement outcome, the observation of change and continuity following loss involves a great deal (Raphael, 1983; Smeding, 1996; Stroebe, Stroebe, & Hanson, 1993). The manner in which the bereaved remember, internalize,
and maintain continued psychological involvement with the deceased is also central to bereavement outcome. People remember, imagine, accompany and separate from their loved ones in their internal psychological world in ways that mirror the nature of how ongoing relationships to living people are represented and maintained in the psychological world. At levels of conscious and unconscious psychological organization, every individual has a complete set of mental representations associated with significant people. The loss of a relative tends to destabilize the mental picture of the deceased and its meaning for the bereaved. As time passes, there will be changes in the mental representations of the deceased that will remain within the heart of the bereaved. We shall return to consider the importance of the relationship to the internal psychological representations of the deceased (Bowlby, 1969/1980; Klass, Silverman & Nickman, 1996; Rubin, 1984b, 1992, 1993).

**The Two-Track Model of Bereavement - A Balanced Model**

Relatively early in my study of loss and bereavement, I had concluded that two main approaches have influenced and often underlie the bulk of the research and clinical literature associated with the field of loss (Rubin, 1981). The first approach considered separation from the deceased as the heart of the response to loss (Freud, 1917). In accord with the psychodynamic and interpersonal approaches to loss, this framework considered the effect of loss through the prism of a weakening or change in the tie to the deceased. In the absence of the bereaved’s return to earlier levels of functioning following grief, it was assumed that there is a continuing difficulty in the working through of loss, and particularly in separation from the deceased. This difficulty may be reflected in somatic or psychiatric symptoms, in emotional, interpersonal, or cognitive difficulties, but in any event, the precipitant and maintaining cause was in the difficulty in “separation” from the deceased (Stroebe, Gergen, Gergen, & Stroebe, 1992; Volkan, 1981).

The second major approach was drawn from a more empirically oriented perspective and viewed the outcome of the bereavement
experience as a biological, behavioral, cognitive, and emotional process fundamentally similar to the response of individuals to situations of crisis, trauma, and stress (Crisp & Priest, 1972; Schut, DeKeijser, van den Bout, & Stroebe, 1996). This being the case, researchers and clinicians associated with this approach were relatively unconcerned with the significance of the bond to the deceased and its meaning for recovery from loss. Instead, the extent of change and difficulty following loss were assessed in their own right. Measuring the various components of day-to-day functioning prior to and following loss made it possible to estimate the extent to which the bereaved continue to suffer the aftereffects of bereavement in their various life activities (van der Kolk, McFarlane, & Weisaeth, 1996).

Although each approach to the field of loss had merit and value, there was a basic need to combine the two. As a result, in a series of theoretical and research articles, a bifocal approach to bereavement was advocated (Rubin, 1981, 1982, 1984a, 1984b, 1985). The process of adaptation to bereavement is linked to the disruption and achievement of new levels in homeostatic functioning. The disruption also occurs in the natural course of the relationship to the deceased, which also requires reorganization. Therefore, it was only logical to consider bereavement from both perspectives. The name given to this approach became the Two-Track Model of Bereavement. It was set forth to incorporate the principal domains of the bereavement process and to reiterate from both a clinical and research perspective that response to loss must be understood as it relates to both the bereaved’s functioning and the quality and nature of the continuing attachment to the deceased. In the attempt to bring the study of trauma and loss into alignment, an approach that emphasizes the continuing relationship to the deceased, while remaining attentive to the indicators of functioning that are disrupted, has particular value. Under varying conditions of stress, bereavement, and trauma, and at any time, we can choose to examine how functioning and/or the relationship to the deceased are proceeding.

The Two-Track Model of Bereavement includes the following main features. First, an understanding that bereavement response occurs along two main axes, each of which is multidimensional. The first axis or track is reflected in how people function naturally
and how this functioning is affected by the cataclysmic life experience that loss may entail. The second axis, however, is concerned with how people are involved in maintaining and changing their relationships to the deceased. The bereaved may not always appreciate the extent or be aware of the nature of this relationship and their investment in it, or of their consequences. Nonetheless, this component is critical for what the human bereavement response involves across the life cycle.

Second, the implications of the Two-Track Model of Bereavement are relevant for theory, research, and clinical and counseling intervention. One can always ask to what extent the bereaved’s response along each of the tracks of the model is addressed and understood.

Third, the clinical implications of the model derive directly from the focus on both the functional and relational aspects of the response to loss. The extent to which interventions deal with either one or both domains of the response to loss are emphasized by the bifocal nature of the Two-Track Model of Bereavement. A schematic visual representation of the model in clinical use is contained in Figure 1.

The level of the individual’s general functioning is conceptualized as reflecting aspects of his or her ability to reestablish an adaptive reaction to life across a number of domains. Reflected in

**FIGURE 1** The Two-Track Model of Bereavement—A multidimensional view.

- **TRACK I - FUNCTIONING**
  - Anxiety
  - Depressive Affect and Cognitions
  - Somatic Concerns
  - Symptoms of a Psychiatric Nature
  - Familial Relationships
  - General Interpersonal Relations
  - Self-esteem and Self-worth
  - Meaning Structure
  - Work
  - Investment in Life Tasks

- **TRACK II - RELATIONSHIP to the DECEASED**
  - Imagery and Memory
  - Emotional Distance
  - Positive Affect vis-a-vis Deceased
  - Negative Affect vis-a-vis Deceased
  - Preoccupation with Loss and the Lost
  - Idealization
  - Conflict
  - Features of Loss Process (Shock, Searching, Disorganization & Reorganization)
  - Impact upon Self-perception
  - Memorialization and Transformation of the Loss and the Deceased
Track I, the range of aspects of the individual’s functioning across affective, interpersonal, somatic and classical psychiatric indicators is considered. Each of the 10 features depicted is noted for its importance in the literature and in people’s response to bereavement. For example, the anxiety and depressive components of the response to loss are central to most clinicians’ assessments of individual functioning. Similarly, the state of the bereaved’s religious and/or other meaning matrix is important for understanding the extent to which the bereaved may have been disconnected from fundamental belief networks that provide critical inner emotional support (Neimeyer, Keese, & Fortner, in press). The extent of interpersonal interactions signifies more than just the support available. Both for family and other relationships, much can be understood from an examination of the state of the relationships. The ability of bereaved people to be invested in something beyond their own grief and mourning is a critical feature in identifying those who are stymied by their loss and those who have reentered somewhat the stream of life (Wikan, 1988). As is true for the bereaved’s ability to manage interpersonal relationships and work, the ability to invest in life tasks in a balanced fashion is one of the major benchmarks for understanding the response to loss (Rubin, Malkinson, & Wiztum, in press-a).

Track II, the relationship to the deceased, is broken down into 10 subareas that capture the salient features of the interpersonal relationship to the deceased. First, the extent of the imagery and memories that the bereaved can and does experience, as well as the emotional distance from them, set the stage for the understanding of the relationship to the deceased. The positive and negative affects associated with memories of the deceased, the extent of preoccupation with the loss, and the indications of idealization of and conflict with the deceased provide a complex picture of the nature of the bereaved’s cognitive and emotional view of the deceased. Included here is also the evaluation of the bereaved’s construction of the loss experience in line with the classic stage theory of Bowlby and Parkes (Bowlby, 1969/1980; Parkes, 1986). Analysis of the degree to which the bereaved’s description of the deceased can be understood as reflecting disorganization versus reorganization, the range of the elements of shock and seeking the deceased and memories of him or her, can be considered here. The extent to which
thinking about the deceased leads to a negative self-view (e.g., I feel guilty whenever I think of the deceased) (Horowitz, Wilner, Marmar, & Krupnick, 1980; Horowitz et al., 1984) can help us understand the ways in which the bereaved constructs the relationship vis-à-vis the deceased (Rubin, 1998, in press-a; Sadeh, Rubin, & Berman, 1993). Finally the memorialization process, and the way in which the bereaved has transformed the relationship with the deceased into something more, whether in ways of identification or formal or informal memorials, provide important information on the ways in which the loss of a person has been transformed into something beyond grief and mourning and shades into the life fabric (Pollock, 1989; Rubin, 1985; Silverman, Nickman & Worden, 1992).

**Representative Research**

To further our understanding of the model’s interplay of theory, clinical material, and research, I shall refer to three studies that colleagues and I have conducted. These studies demonstrate from a research perspective what is involved in considering the multidimensional domains of the Two-Track Model of Bereavement.

**Study 1: The Chicago Sudden Infant Death Syndrome (SIDS) Study—Bereaved Mothers**

The first study was conducted while the model was still in its formative stages (Rubin, 1981). The basic hypothesis underlying the research focused on the transforming nature of sudden unexpected loss for young mothers with the assumption that this loss experience would leave a notable and permanent residue in its wake. Ultimately, the basic hypothesis confronted face-to-face the complex reality of bereavement, which is never quite so straightforward or direct. The study itself focused on an in-depth assessment of 30 young mothers who had lost an infant to SIDS in Illinois, and another 15 mothers who had not experienced child or spouse
loss. Half of the bereaved mothers had experienced the loss an average of 7 months earlier, and the other half had experienced the loss an average of 4 and a half years earlier.

A summary of the research results is contained in Figure 2. As can be seen on measures of general functioning, Track I, functioning was impaired (attributed to the impact of loss and mourning response) and pronounced for recently bereaved mothers but not for nonrecent mothers or no-child-loss mothers on measures of anxiety, evaluation of the present, and on resilience to adversity. On measures where only the bereaved groups were compared, a number of changes in meaning structure and specific life goals were found to characterize both of the bereaved groups, with no differences between them. In contrast, on measures assessing and demonstrating the ongoing preoccupation with the deceased (Track II), both groups demonstrated this pattern. Although the recently bereaved mothers were somewhat more involved, the degree to which the nonrecently bereaved mothers were involved was striking as well. In short, support for ongoing involvement with the deceased and the impact of its loss on personality were in evidence. The results have been discussed in detail elsewhere (Rubin, 1981, 1982, 1993) and were in line with the need to redefine loss and mourning as a process whose impact is neither

![Figure 2](image)

**KEY**
- Recently Bereaved = A
- Non-Recently Bereaved = B
- No child loss = C

**Footnotes**
- 1 = A vs. C are significantly different
- 2 = A vs. B + C are significantly different
- 3 = A vs. B are significantly different

**FIGURE 2** Chicago SIDS study (Rubin, 1981).
clearly time-limited nor leads to a complete separation from the deceased (Klass, Silverman, & Nickman, 1996; Rubin, 1984a). Statistical findings, however, cannot easily convey the power of the loss and what the interview and direct contact with the bereaved conveyed. Participants in this research study provided numerous individual portraits that were eloquent to the powerful and continuing impact of this loss. Mothers spoke of their feelings following loss with varying degrees of openness and psychological awareness. In addition to the continuing attachment to the memory of the deceased, a recurrent theme of a consistent and nagging sense of guilt was present. This feeling was quite prominent and continued for many years. Some mothers referred to it spontaneously and some only after prompting. There were many examples of guilt feelings rationalized and put in perspective but which would not go away. These guilt feelings are first and foremost a reflection of difficulty in the relationship to the deceased and in the meaning of the loss.

Mother: “I know this isn’t true, but my baby died because I did not love him enough.”

Another: “My baby died because my husband and I were fighting during the pregnancy and that weakened the fetus’s development.”

“I’ll always wonder what I could have done,” was one mother’s parting statement to the interviewing researcher.

In contrast, another finding reflected changes in ways of approaching the world that primarily suggested changes in family relationships characteristic of Track I. Both recently and nonrecently bereaved mothers were concerned about the safety of their children, husbands, and themselves and spoke of their awareness of the situations in life which could befall each of them. Over-protection and/or withdrawal from their children were among the results in the first year of loss. The nonrecently bereaved mothers (4.5 years after loss) varied in terms of the severity of their responses. Mrs. Dunne, aged 32, lost her firstborn child 5 years earlier, and has had two children since then. A somewhat anxious and sad woman, she told the interviewer of having lost her “light-heartedness” after her baby died. She had difficulty thinking about the future and worried about the survival of her children, her husband, and herself. “I often wonder if Richard (new infant) will
be with us next month.’’ She described herself as thinking about her dead child frequently. She added that when she saw neighborhood children who would have been “Tom’s” (her SIDS child) playmates, or when she met a Tommy who was 5 years old, she thought of her son again—not as he was then, but as he would have been had he lived (Rubin, 1993, p. 351).

**Study 2: Parents Bereaved of Adult Sons to War**

The results of the former study raised questions as to the nature of bereavement’s impact on parents, the meaning of recovery and resolution in the years following the death, and the ways in which to conceptualize an adaptive and a maladaptive ongoing relationship to the deceased. This next research project was predicated on the assumption that it would be possible to identify problematic responses to loss according to variables of both functioning (Track I) and attachment to the deceased son (Track II) (Rubin, 1987, 1990, 1992).

The study focused on the loss of adult sons to war in Israel where a series of wars had created cohorts of bereaved parents. Parents bereaved in the 1973 Yom Kippur war and the 1982 Lebanese war were selected for the study. In 1986, 4 and 13 years after loss, it was hypothesized that most people would “get on with their lives” and fit the hypothesized model of “resolution” of bereavement. Alas, here too reality was complex and different from what was expected. The participants were 102 bereaved and 73 nonbereaved parents who participated in a comprehensive study involving lengthy questionnaires and extensive interviews.

The first set of results compared the no-child-loss group with the bereaved and found statistically significant differences on measures of general functioning (see Figure 3). The results of the PGEIT2 measure (a revised Grief Experience Inventory [Sanders, Mauger, & Strong, 1979] that removed all bereavement items to become a measure of functioning alone) were overshadowed by pronounced differences between the bereaved and nonbereaved parents’ anxiety measures. On the indices of anxiety, the bereaved parents’ group were significantly more anxious than the nonbereaved group. All these results were interpreted as reflecting features associated with the domain of Track I, functioning.
On the measures associated with relationship, Track II, other important differences emerged between the bereaved and non-bereaved groups. On measures rating how the sons were perceived, it was the no-child-loss parents who rated their sons less favorably (Levi, 1989). Quantitative analysis of the written descriptions of the living and deceased sons highlighted another aspect of the differing construction of the relationship. The nonbereaved described their living sons with a greater degree of interpersonal distance, conflict, and separation than did the parents describing their deceased children. In other articles, I have described the extent of preoccupation with the deceased son that characterizes many of these bereaved parents. In many cases, it is the absence of normal frustrating interactions in life that can serve to make the recollected relationship to the son particularly "seductive." This has many implications for the entire family, in particular for living children whose comparison with the idealized deceased child can be especially problematic (Rubin, 1993, 1996).

The extent to which parents can be preoccupied and attached to the memories and representations of the deceased at the expense of other children can be seen in the following quote from a mother. In this case, problems of functioning and relationship to the deceased come together in the vignette.

It was 14 years ago. The city military officer came with my husband to tell me my son had been killed. I couldn’t believe it when they told me. I didn’t think I could handle it. . . . Our relationship had been so close I couldn’t
find anything negative to say about him. He had been so special. I lost the thing that was most precious to me, the most precious thing of all.

[Interviewer: What was the first year of loss like?] I kept on working. I waited for him every Friday afternoon to come home and he didn’t. I had dreams about him all the time. I would dream that he was alive and I would tell myself in that dream that he really wasn’t. I missed him so much on weekends and holidays. . . . I was jealous of his friends that were still alive . . . I thought a lot about what to do given my situation, given the other kids. [What do you mean?] I thought a lot about whether to kill myself.

[And today?] Well it is true, that time helps and my friends did too. Yet I live with him all the time. He is with me always. I close my eyes and travel with him on the bus. When I pass groups of soldiers I look for him. I can’t do volunteer work with them because it is too powerful, the looking for him.

[What thoughts do you have?] I think about him, about who he would have been today. How he would be married, what his children would have been like, my grandchildren. I think about this all the time. I miss that so much, that he and his children would have come. Perhaps when I die, we will meet again. I never used to think about that, but now I do.

This mother gives a poignant example, not only of the impact of the loss in the first years of bereavement, but of the continuing involvement with the deceased that can be so significant in child loss of all ages. To reiterate, looking through the bifocal lens of the Two-Track Model of Bereavement, we find evidence in this second study for some indications of continuing difficulties in Track I, functioning, and on Track II, relationship with the deceased. Whereas the younger parents of the Chicago study did not manifest continuing effects of the loss on Track 1, the older parents among the Israeli war bereaved parents did.

Study 3: Lay Attitudes Toward the Loss Process

The 3rd and final study moves from an investigation of bereaved individuals to a view of society’s perception of what and how bereavement proceeds. Netta Schechter and I examined how people conceptualized the response to loss, and what they thought were indications of how it was proceeding and what was normative for middle-aged men in Israeli society (Rubin & Schechter, 1997).

In this study we sought out a random sample of individuals to consider their perceptions of loss for middle-aged men. We asked
this group of “nonbereaved” people (although some had been bereaved of family members over the years and the effect of that fact on the results was analyzed), college-age students and parents, to share with us their understanding of the mourning process. We advanced three hypotheses: (a) that loss of adult children would be perceived as more painful and more difficult to respond to than loss of spouse; (b) that normative indicators of a continuing relationship to the deceased would be perceived as continuing longer than difficulties in functioning; and (c), that when presented with problems of functioning (Track 1) and/or problems of relationship (Track 2), problems of functioning would be seen as much more significant than problems of relationships.

We did find support for our three hypotheses. First, in our study, the participants rated the loss of adult children as more painful for adult men than the loss of a spouse. Second, with regard to functioning and relationship, factor analysis showed that two factors could classify the majority of how the participants evaluated the response to loss, and that these factors closely paralleled the parameters of the Two-Track Model of Bereavement (Rubin & Schechter, 1997). Furthermore, as predicted, participants rated problems in functioning as overwhelmingly more significant in determining problems following loss than difficulties in the relationship to and with the deceased (see Figure 4).

This study supported the view that for the majority, how response to loss is viewed is rooted in the way individuals are perceived to function. The predominance of the Track I domain is of concern. As a clinician and humanist, I must wonder about the predominance of the focus on functioning in people’s view of response to loss. As long as functioning is overwhelmingly dominant, serious disturbances in the nature of the ongoing relationship to the deceased will continue to escape attention. This will undoubtedly have potentially negative consequences on the mental and physical health of the bereaved populations.

Having presented three studies from my own research group, it is instructive to turn to the work of others as well. Support for the use of a Two-Track Model of Bereavement emerges from the research of Prigerson and colleagues (Prigerson et al., 1995, 1996, 1997). In a series of studies, this group sought to determine whether a set of symptoms could be identified and distinguished
in/from bereavement-related depression and whether the presence of complicated grief would predict enduring functional impairment. The first study included a group of 82 recently widowed elderly individuals. The authors’ conclusion was that symptoms of complicated grief (relating to the difficulty in the relationship to the thoughts about and memories of the deceased) are distinct from depressive symptoms and appeared to be associated with enduring functional impairments. When the symptoms of complicated grief are present, it is appropriate to define the loss response as a unique disorder deserving specialized treatment apart from that for depression. According to this survey, the symptoms that composed the complicated grief were mainly preoccupation thoughts with the deceased, yearning and searching, feelings of disbelief and being stunned by the loss. Complicated grief emerged as a discrete set of symptoms that were relatively independent of the symptoms of the bereavement-related depression. The depression was characterized by depressed mood, anxiety, insomnia, guilt, hypochondria and apathy, and a decline in functioning. In other words, the inclusion of features associated with the relationship to the deceased was important in the identification of bereavement-related difficulties that are distinct from depressive symptoms. In a replicated study of a nonclinical group of 150 widowed individuals, the results confirmed the first study’s findings and demonstrated again that the

FIGURE 4 The Haifa study: Predictors of perceived bereavement difficulties for adult males.
distinction between complicated grief and symptoms of bereavement-related depression and anxiety was meaningful.

From a diagnostic and clinical perspective, Horowitz and colleagues (Horowitz, Bonanno & Holen, 1993; Horowitz et al., 1997) have advanced suggestions for diagnostic criteria for complicated grief disorder that are relevant as well. They too emphasized the importance of features associated with the relationship to the deceased in the evaluation of outcome to loss, although they do not seek to separate biobehavioral components from relationship components, as we do here. More broadly, the emphasis on the ongoing relationship features to the deceased of a range of researchers and clinicians has been found in the book *Continuing Bonds* (Klass, Silverman, & Nickman, 1996). The importance of the study of continuing relationships for bereavement cannot be overemphasized. It would be unfortunate if the pendulum were to swing so far as to exclude the study of functioning, but at present this is not a source for practical concern.

**Clinical and Therapeutic Applications of the Model**

*Coping, Recovery, and Resolution of Bereavement*

What is to be expected of bereaved people years after a loss? How will life be lived following the conclusion of the mourning process? Answers to questions such as these are inherent in the use of terms, such as recovery following loss or the resolution of bereavement (Malkinson, Rubin, & Witztum, 1993). From the perspective of the Two-Track Model of Bereavement, it should be evident that the outcome of loss needs to be examined along the dimension of functioning, where the term *recovery* might well be adequate, and along the dimension of the continuing relationship to the deceased, where *resolution* is the more precise term. In considering the impact of bereavement on the individual years following the loss, it is well to keep in mind that both recovery and resolution range across the continuum, with varying degrees of adjustment, coping, and a continuing relationship to the representation of the deceased that is neither fixed nor static (Engel, 1961; Exline, Dorrity, & Wortman, 1996).
It is possible to speak of resolution of bereavement as the process that may develop or accompany adaptation to loss. The relationship to the deceased and his or her representations continues as a focus of the bereaved throughout the life cycle. It is characterized by memories, images, emotions, and associations to the representations at both conscious and unconscious levels. The continuing relationship to the deceased is similar to the relationship to representations of living individuals as they are experienced in the emotional realm (Sandler, Dare, & Holder, 1972). The more comfort and openness characterize the connection with the representations of the deceased, the greater the likelihood that the expression resolution of bereavement is appropriate (Rubin, 1984a, 1984b, 1985).

The relationships between the mental representation of self and other, in this case of the bereaved and the deceased, are bidirectional (Horowitz et al., 1980; Rubin, in press-b; Sandler & Sandler, 1978). In the direction of the relation of self to other, we would expect that the experience of the deceased and the relationships to him or her would be open to change and development. They should not remain frozen or fossilized in time. The way the deceased was perceived in the past cannot continue to exist unchanged in the present without extracting great emotional cost from the bereaved. Similarly, the involvement with the past relationship cannot serve as a replacement for relationships of the present but only as an adjunct to them.

In the other direction, the relation of the deceased and its impact on the self-representation, we ask “What are the influences of the involvement with the representation of the deceased? Do memories serve to arouse feelings of relative safety or of tension and discomfort?” If memories and thoughts surrounding the deceased arouse feelings of guilt, anxiety, depression, or pronounced feelings of relief and triumph, it is difficult to speak of resolution of the loss and relations with the deceased. If, however, the memories and thoughts are available in a balanced fashion and provide a measure of strength, warmth, and solidity to the core experience of the bereaved, it is appropriate to think of resolution of the loss. When memories of the deceased remain with the bereaved rather than in opposition to the self-system, when they are neither too central nor too distant, we can understand that the memories of
the deceased have found an appropriate resting point in the life of the bereaved. Changes in the relationship to the deceased will continue to occur across the life cycle. This happens in a manner similar to the way the changes in relationships with living people occur. The presence of flexibility and resilience in the internal object world are important features in the individual’s ability to deal with the ebb and flow of a life course (Schafer, 1992).

The description of resolution of bereavement presented here is an illustration of a desired outcome to the response to loss process (Klass, 1988, 1996). In many cases, however, this desired outcome is far from achieved (Bowlby, 1969/1980; Rando, 1993; Rubin, 1986, 1987, 1990, 1992). Nevertheless, the thesis of this article is that it is necessary to look beyond the level of functioning following death as we attempt to further our understanding and our ability to intervene following loss and mourning (Neimeyer et al., in press; Rubin & Nassar, 1993). Clinical and research approaches alike stand to benefit as we learn to ask questions about the meaning of the deceased in the life of the bereaved, both past and present. Focus on the development and continuing changes in the relationship to the deceased expands our view beyond mere adaptation following loss (Klass, Silverman & Nickman, 1996; Malkinson, Rubin, & Witztum, in press).

Ultimately, four major points serve to orient the observer to the bereavement process from theoretical, research, and clinical perspectives across the perspective of time. At each point, one can use the paradigm of the Two-Track Model of Bereavement to consider how the loss is being assimilated.

First, the experience of the loss of a close relationship has a major impact on the bereaved. In the wake of the loss, fixed patterns of homeostatic functioning will undergo change in intrapersonal, behavioral, biological, and interpersonal areas. When the initial response to loss has subsided, we expect a return to adaptive functioning (Stroebe & Stroebe, 1987). This is not to imply, however, that the homeostasis and functioning achieved are identical to what characterized the bereaved prior to the loss. Although the mourning process generally concludes with the bereaved able to return to living life adequately without the deceased, it is insufficient to examine coping, function, or the ability to form new relationships as the only indices of adaptive conclusion of the
bereavement process. The loss process will usually touch on the ability of the bereaved to reorganize and access thoughts and memories of (the internal relationship with) the now-deceased loved one to some degree. The experience and preoccupation with these thoughts, memories, and emotions (in the jargon, these representations) are often covert features of the individual’s experience and are not perceived by others.

Second, the initial challenge of the response to loss requires the bereaved to accept the reality that death has occurred and that it is necessary to limit the life relationship with the deceased. (This initial period has been referred to in the literature as the acute grief stage [Lindemann, 1944], or as the stage of shock and searching [Bowlby, 1969/1980]). As the weeks and months pass, there are many signs of the dislocation that the bereaved has suffered in bio-behavioral, social, emotional and cognitive realms. As the loss process unfolds, the narrowing of the lived relationship to the deceased is characterized by its opposite, an intensive psychological focus on the relationship and the deceased.

Third, as time passes, the acuteness of the response subsides, and mourning the loved relationship that is loss and the life changes this entails remains manifest, although it varies from person to person. In general, there is a reduction in the intensity of the focus on the reworked attachment to the deceased, as well as a reduction in the extent of the somatic and behavioral changes characterizing the bereaved. At this time (sometimes referred to as the stage of depression or disorganization) there is an ever-deepening appreciation that the living relationship with the deceased is no longer possible (Bowlby, 1969/1980). Some of the changes that buffeted the bereaved will have disappeared and others will recede with time. Along the way, the relationship with the deceased will generally become less central. In this period, the bereaved is generally able to resume satisfactory functioning, with or without significant degree of separation from the deceased (Rubin, 1982, 1990).

Fourth, after the lapse of a significant amount of time (often measured in years), the bereaved will achieve a new level of organization in his or her life. It is now possible to look for a balance along the dimensions of functioning as well as along that of relationship to the deceased (Silverman et al., 1992). At this time, it is possible to regard the axis of behavioral and personality func-
tioning as independent of the axis of relationship with the deceased. Here the two tracks of coping with loss reach a steady state, that may characterize the bereaved across life. The degrees of anxiety and depression, and ability to invest in life and use social supports are by now relatively fixed markers of levels of general functioning. Similarly, the extent, intensity, and frequency with which the deceased is now recollected, the feeling states engendered by thinking of the loss and the lost, and similar indications are now relatively fixed markers of the nature of the ongoing relationship with and attachment to the deceased. The homeostasis achieved at this time allows us to turn to a discussion of the continuing outcome of interpersonal loss, along the two axes of functioning and relationship to the deceased.

**Clinical Perspectives - Case Studies**

Whereas theory and research lay the groundwork for the genesis and clarity of the Two-Track Model of Bereavement, for many it is in the clinical world that the model makes its contribution. Two cases are used to illustrate clinical work. The first vignette presents the clinical assessment of a woman where the focus on functioning is predominant. The second presents the treatment of a woman where the relationship with the deceased was the prominent component of the therapy.

**Case 1: Tanya**

Tanya was a 44-year-old woman who came for therapeutic consultation and entered therapy because of concerns that she was unable to maintain her regular routine and level of activity. In the initial intake meeting, she stressed her inability to function, which had begun “without warning or cause” shortly after her return from a vacation abroad. She was awakening at 3:30 am and was

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1 This case was not part of the original ADEC presentation but is included here for purposes of clarifying the therapeutic applications of the Two-Track Model.
afraid of what the day would bring. Afraid to use the term depression, Tanya recounted symptoms of anxiety, unhappiness, and her concerns about “falling victim to mental illness” and needing hospitalization. Sleep difficulties, abdominal upset, and periods of weepiness all contributed to a picture of depression that she perceived as having occurred totally without cause or reason.

A glance at the application form suggested she was no stranger to loss and bereavement. Subsequent material in the interview soon confirmed how central these features were to the onset of her difficulties. The most recent of her losses was the death of her mother several months prior. Her death had followed a debilitating bout with cancer that had raged for a year. Tanya had selflessly nursed her parent through the progressively worsening illness. She had left no time for herself or her own pursuits as she was wife to her husband, mother to her children, daughter to her own father and nurse to her failing mother. These behaviors seemed self-evident to her.

“I am the only surviving child of my parents so of course the burden falls on me. My sister died suddenly when I was 15, and it was up to me to care for both of my parents and to fill the void left in their lives. I have been similarly occupied for the past 30 years.”

Prior to this crisis in her life, Tanya described herself as an active and competent professional woman who worked in marketing with notable success. She and her husband entertained a great deal and led an active life, all of which had totally stopped given the changes in her emotional life and the “onset of the ‘d-word’ thing—I can’t even say the word.”

As part of the initial intake sessions, Tanya was asked about the relationship with her mother in the more distant past as well as more recently. The questions seemed almost irrelevant to her. She described a conflictual relationship with an opinionated woman who typically got her way in the home by force of personality. Whatever she conveyed, however, was overshadowed by the impression that she did not like to talk about these things and that they were not relevant. It also emerged that she had not grieved or set aside time for mourning her mother—immersion in activity and doing things having taken precedence over anything else. Tanya described her relationship with her father as “not easy,” but she attributed her parents’ strained relationship to patterns character-
istic of “the older generation.” Tanya noted that her father had generally done what his wife had wanted, and found it “surprising that he does not feel free and liberated, but now complains to me that he is alone and expects me to take care of him.”

Listening to her limited descriptions of her relationships with her parents led to a comparison with other relationships. Although generally not able to provide much detail of things in the past or of her own emotional life, Tanya was a reliable informant when it came to describing activities and her relationships with friends in the present. In addition to her description of the present difficulties and relationships with parents, family, and friends, it was important to learn more about the earlier loss that figured so strongly in her history. At this point in the assessment process, however, Tanya’s ability to go into detail (and emotional resonance) with the story was very limited.

I did learn that Tanya’s sister had died suddenly in an automobile accident, and as a result, life had totally changed for her. She described the necessity of her “being strong” to take care of her parents, and how proud she was that she did not cry at the funeral but was on top of the situation. For the next several years, she was the liaison with the outside world, as her mother did not leave home to go out. Her father had been withdrawn as well.

It is hard to convey how difficult Tanya could be due to her constant desire for reassurance and her inability to enter into much detail of the past; however getting the history proceeded fitfully. Tanya wished for reassurance and to be told many things. She wished to be told that her condition was not unusual or serious; that her husband would not have to put up with this for long; that she would become once again an adequate mother and professional; and that she was going to get over it soon. In addition to questions about her general situation, Tanya wanted to know about many other things. She wanted to know if she should stay in bed when she had the urge or must fight to get up. Some of her friends recommended the former and others the latter. What did I the professional think? What about the Xanax medication she was taking—should she continue or not? In consultation with a sleep specialist, she described a new drug that was recommended to her and wanted to know if I had experience with that drug too. The questions were driven by her anxiety, and it was therapeutic as
well as necessary to respond to her at the location of her own experience of her situation. To establish client-sensitive rapport, empathic understanding had to be titrated with some concrete suggestions.

In our third meeting, I began by sharing with her my understanding of her situation and condition. I couched my assessment of her condition in a manner that was honest and supportive. I talked about her depression as generally being self-limiting, and yet how what she was going through seemed to be linked to the loss of her mother and sensitivity to that. I tried to enlist her in the search for meaning to her depression as going beyond the biochemical quirks of life. I suggested that one could think of emotional pain as similar to physical pain. In that case, the pain could be understood as a message that something needed to be looked at and not ignored. If that were true in her case, the onset of her depression and pain could well be related to the relationship with her mother, and to the assumption that she was responsible to act for the benefit of so many others. I indicated it would not be surprising if our discussion would lead us to touch on and deepen our understanding of the loss of her mother as well as that of her sister. But before we did any of that, we had to focus on finding ways to help her return to better functioning, not feel so overwhelmed, and become more relaxed. To do so, we would spend some of our sessions focusing on the problems and questions that she already had.

We discussed the possibilities of a time-limited therapy framework and contact. Somewhat reluctantly, she agreed that referral to a medically oriented psychiatrist with expertise in psychotropic medication was indicated. A twice-weekly therapy meeting for the initial month of treatment was agreed on, as well as reevaluation of the intensity of the sessions to be jointly determined at that time. The initial meetings with Tanya were sufficient to establish a working relationship that she found sympathetic and energizing and treatment began.

**Formulation:** Although there were hints of a complicated relationship to her recently deceased mother, the avoidance of conscious mourning for her death and her wish to return to functioning as soon as possible suggested that both tracks of the Two-Track Model deserved attention. Yet this woman, suffering so intently
right now, required an immediate focus on the functioning aspects of her life. As the initial means of forging rapport with her, and as a means to respond to her anxiety and depression, I focused on her functioning as being her immediate concern. The antidepressant medication, supportive treatment, and attempts to comply with aspects of her wish for directive treatment all revolved around issues of her functioning. For the initial segment of psychotherapy, a focus on the relationship to the deceased would have to assume a secondary and limited role. As long as her insight and curiosity into her problems was so limited, it was proper to meet her where she was ready to be helped.

The therapy contract presented to Tanya allowed for a primary focus on Track I (functioning) and a secondary focus on Track II (relationship). Focusing on her emotional state, the use of psychotropic medication, and discussion of her difficulties would allow us to examine her functioning and support her through her acute period of dysphoria and dysfunction. Her demands of herself further contributed to her difficulties. The bereavement themes, however, also deserved our attention, and the treatment focus would include these as well. Tanya agreed to the contract, and entered into the treatment slightly more relaxed in the knowledge that she had a place where she could share concerns, ask questions, and receive support in her quest to return to functioning. She was skeptical about the need to discuss the loss of her mother and sister but was willing to spend time on that even though she did not immediately feel it was of any value.

In this case, as it unfolded in the first months of treatment, Tanya was primarily concerned with her depression and functioning difficulties. Questions about relationships, complex emotions, or material in the past were perceived by her as intrusive, irrelevant, or both. A constant need for support from a wide range of people supplemented the twice-weekly therapy sessions. As the medication began to take effect and functioning improved somewhat, it became possible to broaden the work with Tanya and add relational themes. Despite the significance of interpersonal loss, the theme of returning to full functioning was what Tanya wished for in therapy. In such a case, it is only proper that Track I, functioning, take precedence as the main
focus of therapy. Features associated with the relationship to the deceased, Track II, must take the backseat in the work for a time.

The next case follows an 18-month treatment for another bereaved woman. In contrast to Case 1, the relationship features of the loss and its treatment will be particularly prominent. In this second case, neither functioning nor symptomatic relief were the focus of the treatment.

Case 2: Nan

Nan was a 36-year-old woman who had been in therapy for a year-and-a-half at the time this material was prepared. She was born into a large Israeli Sephardic-Jewish working class family of Middle Eastern origin. Both her parents were alive, but an older brother 12 years her senior who had been her mentor and “surrogate father” had died when she was 13. Nan explained that she was the youngest child of a large family and the only one that was not married. At the time treatment started she had not established a satisfying relationship with a male figure with whom she wished to live, and because she did not wish to miss the experience of having and raising a child, she was considering becoming a single mother.

Treatment proceeded at a steady pace. In the early stages Nan described tensions with her parents, in particular her difficulties with her father. In dealing with the issue of her relationships with men, the relationship with her father and her deceased brother were relevant. Over the course of treatment Nan began to shift from a Black–White contrast of her father (the less savory figure), who was the villain of the piece, and her older brother, who during her youth had filled many of the nurturing roles and educational roles that her father did not manage. At the time when her father had been perceived as distant and unpredictable, the death of her mentoring brother had been a devastating loss for her. A significant amount of the therapy discussions focused on these two relationships with significant males in her early life.

To understand what was involved, Nan described her responses when she was 13. Within the first months of her brother’s death,
She returned to an age-appropriate level of functioning. Her scholastic and peer activities returned to their pre-loss levels. Although sad and devastated emotionally, she went to a boarding school for disadvantaged youths so as to get away from the oppressive family atmosphere mired in gloom and grief. Her response as a teenager was fundamentally adaptive and functional, but the working through of the loss had been truncated.

**Formulation:** Nan’s perception of her deceased brother was accompanied by positive affect when she thought of him, although there was sadness at his loss. She had an idealized picture of him, and, consistent with the idealization, there was a lack of conflict associated with him. Nan indicated that she thought of her brother daily and also experienced the sadness that was caused by his absence. She felt that in her relationship to her deceased brother, he was a supportive figure, lending his “supportive presence” from within to her life. Her loss response showed evidence of searching for the deceased, and little disorganization and reorganization since his death many years ago. As a 13-year-old, Nan had managed to achieve and hold onto a good relationship with her brother, but it was an idealized picture and one that had not changed significantly over the years.

In the context of a positive therapy relationship, including a willingness to listen to Nan describe the loss of her very special brother, it became possible for her to allow variations and shifts in the story and also to add the perspective of the woman she now was to the perspective of the child she had been. As this was occurring, shifts in her interactions with father began to appear and Nan became more tolerant, less judgmental, and less distancing in her relationship to him.

Conceptually, it appeared that a therapeutic focus on the relationship to the idealized deceased brother, viewed from the vantage point of the young adolescent she had been as he was dying slowly of cancer, might allow her to rejoin the relationship with sufficient flexibility to allow for a less idealized and more complex view of him. Such flexibility might allow her to be more accepting of the living people who were available to her—including her father and others. If these shifts enabled her to be more accepting of the male figures that were out there they would broaden her psychological options regarding the formation of a
mutually satisfying relationship with a man. In retrospect, it seemed that the loss of her idealized brother had made her wary about closeness. He was still remembered in ways that no future husband or therapist or father could hope to compare to, but change was beginning. Therapy seemed to be moving along.

At this stage in the therapy, it was with some surprise that I then learned that there was another player in the family—a sister who had died when Nan was 4 years old. Not mentioned on the application form, and not experienced, this was an important development. Nan was always insistent that she was the youngest in the family—the baby, but she indicated that there was a younger sister too. As we learned more about Anni, who had taken ill at age 2 and died sometime thereafter, it became clear that her existence had been sealed over and entombed for Nan. Within the family of seven other surviving brothers and sisters, the siblings had given versions of the name of the deceased brother to the next generation in a manner consistent with Jewish traditions, but nowhere was the sister Anni memorialized. There were no pictures within the home, no visits to the grave site, and the sister was never discussed among the family. Despite the fact that the older brothers and sisters had interacted with this sister from vantage points of teenagers and the like, the family had “forgotten her” and had not continued to deal with her memory.

As the material around Anni emerged, Nan described the relationship with her sister. Nan talked of how she remembered herself being nice to her sister, playing with her and helping her out. I wondered aloud as to how what she was describing sounded a bit at variance with how many children would have reacted (Silverman, in press–a, b). I remarked that children seemed fairly sturdy and not afraid to be less accepting of new siblings. Children were often concerned with competition and anger at being replaced by another. So perhaps what we were hearing was an adult’s sanitized or Disney version of the child Nan’s responses to her sister. Material confirming this observation soon appeared. In response to these observations, Nan talked about her difficulties in dealing with new people who entered the workforce and organizations where she was employed. Treatment was moving along very well, and the proof lay both in the changes of attitude towards her parents and in the rediscovered life thread of Anni.
Interestingly, as Nan became more aware of the younger sister Anni’s existence, Nan’s view of her deceased brother changed in the direction of greater cracks in the idealization. The view of her deceased sister bore little resemblance to that of the older brother. Nan’s view of her sister Anni was first and foremost one of little information. The degree of constriction, and limits to her recollection of Anni were noticeable. There was a great deal of distance in the description and constriction, absence of positive affect, and evidence of conflict coexisting alongside a state of mourning that can only be described as characteristic of the “searching” phase. Whereas the impact of the representation of Anni on the self was unclear, it was obvious that here was an entirely different way of responding to loss by the same person, and heavily determined by the relationship, identity, and age of the bereaved at the time of loss.

Ultimately, viewing this 36-year-old woman’s relationship to the deceased, we have evidence for some circumscribed difficulty in functioning following loss. The relationship features of her feelings toward her deceased brother had been frozen in the response of the 13-year-old she had been when her brother died. Her early adolescent self had responded to and absorbed much of what had gone on at the time and had begun to reopen the process of having a flexible relationship to the memories of the deceased. In contrast, the difficulties in her relationship with Anni were rooted in the preschooler she had been when her sister died and which her family had frozen as well. This situation had led to significant limitation in Nan’s view of Anni, which required additional attempts to fill in the gaps of memory and affect that had been frozen out of her awareness and consciousness.

We can say that the shifts in the relationship to her deceased brother were relatively limited over the years, so although the functional component of the bereavement process had proceeded to recovery, the relational aspect still seemed to be problematic. With regard to Anni, the continuing nature of the relationship to the deceased shows much greater difficulty. She is in need of more information and detail before mourning can connect the 36-old-woman with the 4-year-old child she had been when her sister died. To reopen the life story of the 4-year-old bereaved girl may help her understand what she might have felt then, and how it
may have influenced her views of herself, her parents, and perhaps her sensitivity to her later sibling loss of her older brother.

It is significant that at the time that the memories of her younger sister and younger self were emerging, Nan responded very poorly to a break initiated by her and by me. As we had cancelled sessions before with no adverse consequences, I was less than prepared for Nan’s response to treatment after a 2-week hiatus. She opened our next session by suggesting that we consider terminating treatment. She believed that therapy was not necessary anymore, and besides, if she wanted to continue she might prefer a woman or therapist who was more talkative in the therapy session. My own reaction was one of surprise and dismay. Emotionally, I responded with the feeling that I was about to be dismissed from the case; I was going to be forgotten—to be replaced by a new therapist, one who would listen and with whom Nan would share her life and who would see her develop instead of me. For the next two sessions, we explored the trigger and source for her thoughts regarding the termination of therapy. Gradually, we were able to comprehend together. It seemed that a portion of the answer lay in the repetition of a configuration she had experienced before. Facing her memories and feelings about her little sister had increased her need to receive support from those around her. When a short treatment hiatus occurred, this linked up to her own sense of re-abandonment by the significant members of her family in ways that echoed the response at the time of the loss of her sister and the loss of her brother. While as a young child her option had been withdrawal, as an adolescent she had left the family and gone to boarding school. Similar impulses had seized her now—both to withdraw and to go to a new place. Talking about these responses in the context of her response to loss proved cathartic and allowed her to continue in treatment. The issues of treatment continued but there were no more crises. A mutually agreed satisfactory conclusion to this stage of treatment and termination of treatment was reached some 6 months later. The termination was marked by greater comfort with her father, her increasingly complex view of her deceased brother, and a sense of openness to all her siblings, both living and dead.

In this case, the Two-Track Model focused us squarely on the relational themes that were present here. It was the attempt to get
The Two-Track Model of Bereavement

The basic thrust of the Two-Track Model is to define a paradigm for the analysis of measurable behavior and cognitive-affective responses to loss. The most salient framework for the examination of the response to loss sets out to consider function and relationship to the deceased. Having spent time to this point on the theory, research and clinical features of the Two-Track Model, it is appropriate to conclude with an eye to the future.

Looking ahead, prospects for the multidimensional focus represented by the model are improving but not assured. One example of positive movement in the field is the shifting relationship between the bereavement and trauma fields. The earlier tension that characterized the overlap between the fields and a shocking lack of cross-fertilization has begun to change. In place of the overspecialization we have known, where people are specialists in grief but not trauma, or the reverse, there is now an openness where scientists and practitioners from each subfield are becoming more familiar with the perspective and knowledge base of the other (Malkinson et al., in press; Stroebe, Stroebe, Hansson, & Schut, in press). One might say that the willingness to learn from the “other” is emerging from a position of respect and curiosity.

In such a climate, the Two-Track Model of Bereavement can help specify areas of mutuality (how people respond affectivity to trauma and change) and also differences (how bereaved people may be preoccupied with the deceased following loss as compared to how they may be preoccupied with trauma following the exposure to it). In the increasingly multivariate examination of response
to loss and trauma, and particularly when these overlap, an over-arching functional and relational model for examining process and outcome following loss is both necessary and useful.

A second area where prospects for growth that are based on the perspective of the Two-Track Model of Bereavement should emerge is the area of cross-cultural approaches to loss. The ways in which the gender and ethnic and religious groups conceptualize and process loss along each of the tracks lend themselves to examination by the model presented here. In Israel today, a place where Jewish, Christian, and Moslem individuals and societies meet and influence each other, the promise of the model’s contribution is slowly being realized. My colleagues and I are working to further the understanding of how sociocultural, professional, and religious perspectives influence the understanding of death of a loved one and the response over years that unfolds (Rubin, Malkinson, & Witztum, in press-b; Rubin & Schechter, 1997).

Ultimately, the bifocal approach of the Two-Track Model of Bereavement combines the behavioral-empirical perspective with the focus on the relationship to the deceased. In so doing, it helps organize our thinking in how we view the worlds of the living and the multiple layers and shadings of the overt and covert aspects of their bonds to those they love. Whereas “until death do us part” has been with us for millennia, it is generally not enough for one partner to die for an attachment and bond with the loved one to end. As long as the memory of and attachment to the deceased exist, the relationship has not ended. By considering and following the changes in functioning and relationship to the deceased over time, we can learn much about both relationship and loss. If the Two-Track Model of Bereavement can help clarify this point to professional and lay audiences, it will have more than justified its contribution to the evolution of our understanding of love and loss.

References


